FISHER COLLEGE

Division of Student Life

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ DATE OF BIRTH:_____

PATIENT ADDRESS: _____

_____

PATIENT TELEPHONE NUMBER: _____

PATIENT STATEMENT:

I _____ (patient name/legal representative) authorize

Name of Physician/Facility_____

Address of Physician/Facility_____

Phone number of Physician/Facility_____

to release Health information, including copies of my medical record to the following:

FISHER COLLEGE

HEALTH SERVICES

118 BEACON STREET

BOSTON, MA 02116

617-236-8860 PHONE

617-236-5465 SECURE FAX

REASON FOR THE INFORMATION TRANSFER REQUEST: College Health Services, continuity of care

INFORMATION TO BE RELEASED: P**hysical Exam and Immunization Records**

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Medical Records Department. This authorization is voluntary. Authorization may be withdrawn except for the following:
    - To the extent that action has been taken in reliance on this authorization.
- Information released, if further disclosed by the recipient is no longer protected by the above-referenced facility.
- I understand that this authorization will automatically expire in 6 months unless otherwise specified.
- I understand that my treatment will not be conditioned on the completion of this authorization.

I have read and understand the above, have had any questions explained to my satisfaction and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

PATIENT'S SIGNATURE:_____ DATE:_____

PRINT NAME:_____